Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Orthopaedic Consultants of North Texas

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-14-2608-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 22, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We understand Texas Mutual requires prior authorization, and would have complied with their policy had we been informed this was a work related injury on day one. This is clearly an exception as (injured worker) failed to disclose that information to us on June 3, 2013. We are being penalized for rendering treatment in good faith. We feel we should be reimbursed for services rendered."

Amount in Dispute: $9,968.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor argues it was given incorrect information by the claimant, which prevented the requestor from obtaining the required preauthorization. The only exception to failure to preauthorize is medical emergency as defined by Rule 133.2. The operative report in the requestor's DWC60 packet does not identify an emergency condition. No payment is due. "

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 14, 2013	Physician services	$9,968.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out guidelines for prospective and concurrent review of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Precertification /authorization/notification absent
   - 193 – Original payment decision is being maintained

Issues

1. Did the requestor support exception to prior authorization rule?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §134.600(c) states in pertinent part, "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care; (C) concurrent utilization review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or (D) when ordered by the commissioner;" Review of the submitted documentation finds no exception to the applicable rule. Therefore, the insurance carrier is not liable for the services in dispute.
2. The requirements of 28 Texas Labor Code §134.600 not met. No payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.